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IMPACT OF COMMUNITY-LED TOTAL SANITATION ON WOMEN'S HEALTH IN URBAN SLUMS: A CASE STUDY FROM KALYANI MUNICIPALITY

Empowerment of Women and Girls

Preetha Prabhakaran, Kamal Kar, Lyla Mehta and Sayantan R. Chowdhury

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IMPACT OF COMMUNITY-LED TOTAL SANITATION ON WOMEN'S HEALTH IN URBAN SLUMS: A CASE STUDY FROM KALYANI MUNICIPALITY

Preetha Prabhakaran,[a] Kamal Kar,[a] Lyla Mehta[b] and Sayantan R. Chowdhury[a]
[a] CLTS Foundation
[b] Institute of Development Studies

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The Evidence Report that this brief accompanies seeks to understand the health and other impacts of slum women's access to sanitation through the Community-led Total Sanitation (CLTS)[1] approach. It also examines the process through which open defecation free (ODF) status was attained in two different slum colonies, the resulting health impacts and the collective action that took place around both sanitation and other development benefits. The study was conducted in the slums of Kalyani, a Municipality town located 55km north of Kolkata, the capital city of West Bengal state in India. From an area plagued with rampant open defecation, the slums of Kalyani were transformed into the first ODF town in India in 2009. This was achieved through the CLTS model that focused on motivating the community to undertake collective behaviour change to achieve 'total' sanitation and an ODF environment. This was in sharp contrast to earlier, top-down approaches to the provision of toilets, which had failed to ensure ownership or usage by the community. The benefits of CLTS to the community were not limited to changed sanitation behaviour and an end of open defecation – there were significant development and health gains beyond sanitation. Women's health in this study has been viewed not just in terms of the presence or absence of disease burden on the physical health of women but also in terms of their socio-psychological wellbeing resulting from reduced risks and a wide range of benefits accruing from better sanitation and hygiene practices and facilities. The study also focused on exploring the extent to which the CLTS process can be said to have empowered women. As experiences of good health and wellbeing are affected by factors in the external environment, namely the role of the local government, women's access to health services and the involvement of multiple sectors, these issues were also considered, in order to understand the overall health status and experiences of women in Kalyani slums.

The study had the following objectives:

1. to understand the impact of improved sanitation and specifically of the CLTS process on women's physical health in terms of reduction in disease burden as well as the social and psychological wellbeing of women in selected slums of Kalyani;
2. to understand the impact of the CLTS process on aspects of women's empowerment and its effect on women's wellbeing and overall health in selected ODF slums of Kalyani;
3. to understand the external environmental factors that have played a key role in improving sanitation in Kalyani and therefore the health of women.

It was conducted in two slum colonies in Kalyani, Vidyasagar Colony and Harijan Para, which were chosen because they were part of the initial CLTS pilot and were the early adopters of the approach. They also allowed the researchers to capture the experiences of two different categories of migrants residing in the slums (namely, Bengali-speaking Hindu refugees from Bangladesh and Hindi-speaking *dalit* migrants from two other states in India, Jharkhand and Uttar Pradesh). This study seeks to capture an emic account of women's health and wellbeing in the Kalyani slums, building on the accounts and perspectives of local women. During the investigation the research team employed a combination of methods for collecting data related to the study objectives. These methods included: focus group discussions (FGDs) with a wide range of women and adolescent girls, including some of the leaders who mobilised the community to take action to change their sanitary and hygiene behaviours; personal interviews (PIs) with some women who played key leadership roles during the CLTS activities; key informant interviews (KIIs) with key institutional actors in

[1] CLTS is a methodology designed to trigger communities to stop open defecation and gain access to sanitation; it was developed by Dr Kamal Kar in Bangladesh in 2000. Since then, CLTS has been rolled out in 69 countries across the globe. Today it forms part of the national strategy of more than 25 countries in Asia, Africa and Latin America. The CLTS methodology involves a series of participatory exercises that empower the community to visually analyse their sanitation situation and the various pathways of faecal-oral contamination in their everyday lives.

order to understand the role of the Municipality in facilitating the adoption of sanitation and hygiene behaviour by the community; and participant observation.

Findings

When CLTS was implemented in Kalyani, open defecation was rampant in almost all slums of Kalyani and consequently there was a high incidence of diseases among the slum children, a relatively high level of infant mortality and maternal mortality rates, a lack of education and awareness about basic hygiene, etc. However, the situation changed drastically after the CLTS process. Overall, women across all age groups from both the slum communities reported reduced incidence of illnesses such as diarrhoea and other health problems, both personally and in their families, especially among the children. This has led to fewer hospital visits and an increase in disposable incomes, due to reduced medical expenditure. Women stated that, with the presence of toilets in their homes, their experiences during menstruation had become more pleasant as they had a private and clean space in which to maintain their hygiene. Women across all age groups expressed a sense of security, safety and convenience due to the presence of toilets in their homes.

Other positive benefits included the time saved for undertaking other activities; the ability to carry out their tasks and daily activities in a more organised manner; and a positive outcome regarding their earnings and livelihood opportunities. Most women expressed a feeling of pride and higher social standing with the ownership of a toilet. Greater consciousness about sanitation had led to an improvement in other living conditions and other collective efforts in both the slum communities. In Harijan Para, women's collective efforts had succeeded in eradicating alcoholism in the community and had led to men realising that they needed to improve their lives. Women had played a lead role in making their communities ODF and this experience had enabled them to exercise agency in many areas of their lives, both within their households and in the community. Women in Harijan Para said that this community-led action had empowered them in many ways and for the first time they were included in decision-making processes in their own homes or in the community, which had given them greater self-confidence.

When CLTS was implemented in the slums of Kalyani, the Municipality played a very limited role in the welfare of the slum communities, not least because the residents were considered illegal occupants. The success of the community members in improving their sanitation status on their own, and the national recognition that the local communities and the Municipality received, resulted in the Municipality being persuaded to pay more attention to the needs of the slum population. As a result, and quite uniquely, the slum communities are now included in urban infrastructural design and planning (e.g. connections to the main sewerage line).

Kalyani stands out because it was the first successful attempt to apply CLTS to an urban context with the aim of fostering collective behaviour change as a strategy to stop open defecation and promote hygiene practices. This led to further improvements to the slum colonies and access to basic services, and to some examples of tenure security. It is also a unique case because in urban sanitation programmes, the needs of the urban poor, especially slum dwellers who are considered unauthorised occupants of the land, are often ignored and bypassed. In urban planning processes, the tendency has been to adopt a technocratic approach relying on standardised top-down solutions, which have usually failed because people either did not use the toilets provided to them or used them for other purposes. CLTS was a departure from the traditional approach of 'prescribing solutions' to the urban poor. Instead, it focused on enabling community members to mobilise for collective action to address their own sanitation needs. Once the community collectively started achieving their sanitation goals, they extended this spirit and energy to gain access to other basic services.

The case of Kalyani is also unique because of several factors that worked in favour of efforts to achieve the success that it enjoyed and still enjoys. One was the political will exercised by the Chairman of the Municipality, and the presence of committed health professionals in his team and of educated ward councillors who understood the benefits of a community-led approach to achieving sanitation outcomes. Second was the direct involvement of Kamal Kar, pioneer of the CLTS approach, in implementing CLTS in Kalyani, with the support received from the UK's Department for International Development (DFID), and the implementation of the Kolkata Urban Services for the Poor (KUSP) project that facilitated the CLTS process at that time. Third, Kalyani was a planned municipal town with upper-middle-class residents, and these families of course were very anxious to have open defecation in their surrounding areas eradicated and they were willing to extend any support to the Municipality for this purpose. There was also enough physical space to build toilets, unlike in inner city slums.

Despite these unique features, Kalyani holds valuable lessons for other Municipalities. These include the fact that local institutional actors must have the political will and necessary commitment to achieving long-term change, as well as the ability to mobilise resources and capacity to work with the community. The Kalyani example also effectively demonstrates the very important role that institutional actors such as politicians, administrators, health workers, engineers, contractors, etc., can play in achieving successful outcomes, not as direct implementers of a sanitation programme or as providers of infrastructure, but as facilitators supporting the community to design and implement its own initiatives.

The challenges in sustaining the achieved health outcomes in Kalyani are numerous, however. There are several issues that potentially could reduce or negate the health benefits gained from CLTS, or even adversely affect the health of the residents, if not addressed urgently. These involve the safe disposal of confined excreta, which is currently done in a manner that is potentially hazardous, both for the environment and for the health and the dignity of the *dalits* who are engaged in manual collection and disposal of human waste in the slum communities. Technology upgrading is also needed, to avoid contamination of water and to ensure that people move up the sanitation ladder in terms of both facilities and behaviour change. The issue of land ownership is very contentious but must be tackled if people are to take ownership and invest in better sanitation facilities. The government programmes also need to be better targeted in order to cover entire populations and support them to upgrade their technologies so as to improve their sanitation and hygiene behavioural practices.

In conclusion, Kalyani shows that it is possible to address sanitation challenges through health initiatives in an urban slum area. Solving the sanitation problem requires a multisectoral integrated approach, with the engagement of multiple stakeholders. At the centre of any initiative, however, there must be the community, who have to take on ownership and accountability for their sanitation and hygiene behaviour and practices. In the case of Kalyani, the role of local women was crucial and they became powerful agents of change. Sanitation also needs to be viewed as a public good that requires collective behaviour change (also on the part of bureaucrats) and action. The achievement of 'total' sanitation or an ODF environment should not merely stop at the construction of individual toilets, but issues such as sustainability, waste containment, livelihood security, gender empowerment, etc., need to be part and parcel of all programmes. Kalyani also provides a strong case for collective community demand and action in activating and strengthening formal health delivery systems and integrating health programmes with sanitation initiatives. The direct outcome of good sanitation is better health, and placing sanitation within health departments (as opposed to departments for infrastructure, rural development, etc.) can make sense. Still, a narrow focus on health benefits can mean overlooking the multiple benefits that sanitation programmes can offer in terms of gender equality. These include issues concerning dignity, security, enhanced wellbeing, education, livelihood security and

bargaining power of women, etc., that cannot be captured within a narrow health lens. These non-health benefits are significant and can also go a long way to helping the realisation of several Sustainable Development Goals (SDGs) and at the same time may enable the achievement of health benefits. Finally, an enabling external environment and conducive institutional context are crucial to helping realise these benefits over and above the collective action undertaken by women themselves.